

# Saint Barnabas Medical Center Hospital Based Educators Teach Optimal Asthma Care

DSRIP Learning Collaborative  
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# Saint Barnabas Medical Center



New Jersey's oldest nonprofit, nonsectarian hospital.

Major teaching affiliate

University of Medicine and Dentistry

New Jersey Medical School

Drexel University

Saint George's University SOM

Clinical Campus

New York College of Osteopathic Medicine.

1,500 physicians and dentists

100 specialties

597-beds

35,000 inpatients

>90,000 adult and pediatric E.D.

300,000 outpatients SBMC & BHACC

# DSRIP—Impact on Barnabas Health

- \$29,038,415 is the HSRF subsidy received by Barnabas Health which will be affected with a pay for performance DSRIP program
- Funding will be based on a weighted factor methodology after the hospitals have met the required performance metrics
- Each hospital's project will be evaluated and given a Percentage Achievement Value (PAV) score
- Approximately \$450,000 at risk for SBMC

# Community Needs Assessment

- Based on SBMC's Community Health Needs Assessment (CHNA) Asthma was identified as an appropriate project
- The CHNA highlights the impact of asthma on Essex County residents:
- 8.3% of Essex County residents reported having asthma in 2010, up slightly from 2004 (8.2%). The prevalence of asthma in Newark, the County's largest city, was 16%.

# SBMC DSRIP Team

- Rick Davis, CFO Executive Sponsor
  - Maria Dimi, RRT, MBA Administrative Director of Respiratory Care & Neuro-diagnostics Services
  - Tara Morella, RRT, BS Respiratory Care Clinical Coordinator
  - Sean Cox, RN, MSN, MAS, CPHQ Director of Quality & Standards
  - Vincent Silvestri, RN, MSN, CPHQ Director of Performance Improvement and TQM
  - Jeanne Kraft, MD, FACP Physician Champion
  - Margie Heller, Administrative Director, Community Health and Outreach
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# Goals/Outcomes

The expected patient outcomes are:

- Reduced emergency room visits for asthma
- Reduced hospital admissions for asthma
- Reduced hospital readmissions for asthma
- Educate the community at large for the triggers, signs & symptoms of asthma

# Certified Asthma Educators

- Eight staff were selected to complete a test preparation course and sit for the National Asthma Educator Certification Board (NAECB) examination.
- All were qualified to be admitted to the examination based on holding the RRT or CRT credential.
- Six successfully passed the exam on the first attempt

# Patient Education

.Asthma Education – The asthma educators will be available, upon request of the patient, family member/caregiver, social worker, or staff nurse, to provide additional training to asthma patients prior to discharge, in addition to a 45-minute bedside session that will be provided earlier during the patient's stay. The patient's action plan will be reviewed again with the patient, recommendations will be reinforced, and any new questions addressed.

- Asthma Action Plan – The patient's asthma action plan, developed by the asthma educators after their bedside asthma training session, will be reviewed by the staff nurse with the patient and family/caregiver in the final discharge planning meeting on the unit prior to discharge. At that time, the staff nurse will confirm the post-discharge medications and call or send the prescription to the patient's pharmacy. Copies of patient self-management tools, such as the peak flow tracking sheet, will also be provided to facilitate compliance with Asthma Action Plan.

- Follow-Up Visit – Staff nurses or social workers will schedule the patient's follow-up appointment with either their primary care physician or pulmonologist prior to discharge and confirm details with patient and their family/caregiver at the final discharge planning meeting. The goal is for the patient to be seen within 7 days of their hospital discharge. Patients will be asked if they have transportation needs or other obstacles that would prevent them from attending their follow-up appointment and referred to a hospital social worker to resolve.

- Home Care Support – For patients who have home care support in their Asthma Action Plan, the asthma educators (who are also respiratory therapists) will participate in the final discharge planning meeting.

Case management care coordination processed documented

# Patient Education Tools

- *Ask About Asthma* – A 13-page patient booklet on asthma explaining the disease, taking medications, lifestyle issues, provider visits, and obtaining asthma support.
- *Using a Peak Flow Meter* – Written and graphic instructions for using a peak flow meter and recording your reading.
- *Peak Flow Tracking Sheet* – Provides a weekly record of patient's daily peak flow readings for the week. Patients will be encouraged to bring this record with them to their follow-up appointments.
- *Your Personal Best Peak Flow Number* – Interprets peak flow readings to help the patient determine how well they are managing their asthma and identifies their asthma “danger” zones.
- *Peak Flow Diary* – Maintains a record of peak flow readings to evaluate patient progress and help determine triggers.
- *Asthma Action Plan* – Identifies patient's asthma triggers, necessary medications, and asthma danger zones (based on peak flow readings), and provides instructions for obtaining help during emergencies.
- *Doc Monaghan Kit* - Provides a Video CD both in English & Spanish to educate children and their families on the topic of asthma, using their meds and equipment.

# Partners

- SBMC initially targeted schools and Day Care centers for delivering Asthma education
- Sessions delivered at these sites were very well received
- Realized we would need to secure partners who could share clinical data with SBMC
- Due to SBMC's payer mix it is a challenge to find DSRIP target partners

# Zufall Health Center

- Zufall Health Center the first FQHC in SBMC's primary service area
- Initial meetings occurred Summer 2014
- MD's will receive appointment to SBMC Medical Staff (Community Staff)
- Concerns about Data Sharing
- Concerns about access to Specialty Physicians and OB Clinic
- Plan to regroup with Zufall and SBMC leadership team

# Project Interventions

- Pilot Survey
  - Small sample size
  - Included all in pilot

# Project Interventions

- Survey for School Partners
  - Developing survey for school partners (school RN's, teachers, staff)
  - Will include evaluation of knowledge pre and post education

# Project Interventions

- Development of ED alert process for patients discharged less than 30 days
  - Respiratory Therapy to receive an alert upon registration
  - Earlier intervention
  - Reducing Asthma readmissions key goal
- Development of ED alert process for patients seen in ED less than 30 days

# Project Achievement to Date

- Certified Asthma Educator
- Collaboration between departments and disciplines
  - Respiratory Therapy
  - Nursing
  - Emergency Department
  - Quality
  - Finance
- Community relationships and partnerships
  - Zufall FQHC
  - Essex County schools

# Challenges

- Patient Satisfaction Survey
  - Worked with Press Gayney to add Asthma education questions to survey
  - Very low response rate
  - Currently developing hand delivered survey which can be provided both to patients educated in the hospital as well as in the community

# Moving Forward

- Partnering with American Lung Association
  - Meeting Scheduled with Dr. Suarez
- Establishing Quarterly meeting with fellow LC1 Participating Hospitals
  - e-mail sent to team
  - Proposal to meet quarterly prior to NJHA “live” meeting

# Moving Forward

- Exploring after-school support group for pediatric and adolescent asthma patients
- Continue to partner with FQHC with goal of establishing “reporting partner” status
- Obtain certification for Asthma Self Management Education (ASME)